PATIENT INTAKE FORM

Patient Name _____Home Phone _____

Street Address _____ Cell Phone_____

Mailing Address _____ Work Phone_____

City_____ Email_____

State_____ Zip Code_____ Date of Birth_____

May I call/text message you at the above numbers? Y or N

May I leave a message at this email address? Y or N

Legal Sex: _____ Marital Status: S M D W

Do you identify as transgender? ____Preferred pronouns: _____

Primary Care Physician (PCP) _____ PCP Office Phone_____

PCP Address _____

Are you a full-time student? Y or N What school? _____

Are you seeing another therapist for mental health services? Y or N

Would you like to leave your credit card information on file? If not, I'll collect payment after each session. If yes, please fill out the following:

Credit Card #: _____

Expiration Date: _____

CVV (3 numbers on the back): _____

Billing Zip Code: _____

Client Information & Informed Consent

Therapist Orientation and Credentials: The undersigned therapist is a Board Certified Sex Therapist, Nationally Certified Counselor, and a Licensed Mental Health Counselor in the State of Florida engaged in private practice providing mental health care services to clients. This clinician often focuses on issues around communication, self-care, and self-actualization and typically uses a mix of rational emotive behavioral therapy, narrative, and cognitive behavioral therapy as appropriate for each client's needs. Rational emotive behavioral therapy focuses on identifying, challenging, and replacing client's self-defeating thoughts and beliefs with healthier thoughts that promote emotional well-being and goal achievement. Narrative therapy is a collaborative process in which clients can discover possibilities contained within themselves and create new stories of their lives. Cognitive behavioral therapy works to replace maladaptive thoughts and beliefs with adaptive ones in efforts to create more positive behaviors and feelings for the client. Please discuss any concerns or questions you may have regarding your treatment at any time during the process.

Mental Health Services: Therapy is a collaborative process between you and a therapist/counselor to work on areas of dissatisfaction in your life and assist you with your life goals. It is hoped that you will be better able to understand your situation and new ways to approach situations. It will be important for you to explore your own thoughts and feelings and try new approaches in order for change to occur.

Appointment Scheduling & Contact Information: Appointments are made by contacting me at (727) 300-6688 or drkatieschubert@gmail.com between the hours of 8 a.m. and 8 p.m. any day. Messages can be left on this confidential voicemail as needed for scheduling appointments. Therapy appointment are typically scheduled Monday-Saturday between the hours of 9:00am-6:00pm EST. Some evening and Saturday appointments are available. Counseling sessions will typically last 35-55 minutes. The counseling appointments are generally scheduled once a week, or once every other week. The number of therapy sessions you will have depends on your needs and therapy plan. We will discuss the process and length of treatment on an ongoing basis. Appointments need to start and end on time, and excessive tardiness or cancellations may result in termination of services. Please notify the therapist at least 24-hours in advance to cancel or reschedule, or you may be charged the full fee for the missed appointment. The client consents for the undersigned therapist to communicate by mail, e-mail, and phone at the addresses and phone numbers provided on the Client Intake Forms, and the client will IMMEDIATELY advise the therapist in the event of any change of address or phone on the original intake forms. The client understands that e-mail and texting may not be confidential.

Goals, Purposes, and Techniques of Therapy: There may be alternative ways to effectively treat the problems you are experiencing in addition to the types of therapies I typically use and set forth above. It is important for you to discuss any questions you may have regarding the treatment recommended by your therapist and to have input into setting the goals of your therapy. As therapy progresses these goals may change. Your initial goals are as follows: Please describe, in your own words, your goals for therapy at this time....

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Therapeutic Relationship: The relationship between therapist and client is the instrument through which client change can take place. Because of this, it is often one in which a close emotional bond develops. It is also a professional relationship, in which appropriate boundaries must be maintained. The therapeutic relationship begins and ends in the context of the counseling session. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. Although this is sometimes difficult to understand, it is a necessary requirement for maintenance of a safe and effective therapeutic environment. While the therapist cares about the client, the therapist is not is a position to be a friend. Please discuss any questions, concerns, or feelings about this with the therapist.

Please initial each page: _____

CONFIDENTIALITY: Discussions between a therapist and a client are confidential. No information will be released without the client's written consent or unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority. In addition, when doing couples or family therapy, the family unit or couple is the client and all parties must sign a release of confidentiality for any part of the record to be released. All efforts are made to protect confidentiality and clients are discouraged from having their therapist subpoenaed or having records provided for litigation since this can often bring about a conflict of interest and undermine the therapeutic relationship. Although it is my goal to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by law. In the event disclosure of your records or testimony is required by you or by the law, you will be responsible for and shall pay the costs involved in producing the records and for the time involved in preparing for and giving testimony at the therapist's hourly rate of $125/hour. Such payments are to be made prior to the time of services. Therapist may require a deposit for anticipated court appearances and preparation. Records will be kept by the therapist for the designated required time period in your state. FOR FURTHER INFORMATION REVIEW THE NOTICE OF PRIVACY PRACTICES FURNISHED TO YOU BY YOUR THERAPIST IN CONJUNCTION WITH THIS CLIENT INFORMATION AND CONSENT DOCUMENT. If you have any questions regarding confidentiality, bring them to the attention of the therapist when you and the therapist discuss this matter. By signing this information and consent form, you are giving your consent to me, the undersigned therapist, to share confidential information with all persons mandated by law and with the agency that referred you and you are also releasing and holding harmless the undersigned therapist from any departure from your right of confidentiality that may result.

Duty to Warn: In the event that I, the undersigned client, reasonably believe that I am a danger, physically or emotionally, to myself or another person, I specifically consent for the therapist to warn the person in danger and to contact any person in position to prevent harm to myself or another person, in addition to medical and law enforcement personnel, and the following persons:
FULL NAME / TELEPHONE NUMBER: _____
This information is to be provided at my request for use by said persons only to prevent harm to myself or another person. This authorization expires upon the termination of therapy with the undersigned therapist. I acknowledge that I have the right to revoke this authorization in writing at any time to the extent the undersigned therapist has not taken action in reliance on this authorization. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be permitted by law as indicated in the copy of the Notice of Privacy Practices of the undersigned therapist that I have received and reviewed. I acknowledge that I have been advised by the undersigned therapist of the potential of the redisclosure of my protected health information by the authorized recipients and that it will no longer be protected by the federal Privacy Rule. I further acknowledge that the treatment provided to me by the undersigned therapist was conditioned on my providing this authorization.

Hold Harmless: I agree to hold harmless the Provider, Dr. Katie Schubert, from and against all losses, expenses, damages and costs, including reasonable attorney's fees, relating to or arising from any information loss due to technical failure, my use of the internet to communicate with the Provider or the use of the Provider's web-site, any arrangements you make based on information obtained by the Site, any products or services obtained through the Site. The Provider does not warrant that the functions contained in any materials provided will be error-free or that the Provider's website or server that makes such site available is free of viruses or other harmful components.

Please initial each page: _____

PAYMENT & BILLING: My charge for therapy is $125 for an individual 45-50 minute therapy session and $150 for a 45-50 minute couple session. Payment may be made in full prior to the session by cash, check, or credit card. Fees for court services of any kind are $300 per hour. Credit cards can be kept on file in your secure online medical record and charged each visit as agreed upon. I do not accept insurance, but will provide receipts for out of network reimbursement.

Benefits and Risks of Counseling: Therapy is the Greek word for change. The benefits of counseling can include a better understanding of yourself, improved communication with friends and family, positive coping skills, and clarity in your life. The therapeutic process may involve some risks too. Some clients experience a temporary increase of their symptoms before the long-lasting positive changes can occur. Often growth cannot occur until you confront issues that may cause you feelings of sadness, anxiety, or pain. The success of our work together depends on the quality of the efforts on both our parts and the realization that you are responsible for lifestyle choices or changes that may result from therapy. Please discuss any questions or concerns regarding the benefits and risks throughout the counseling process.

After Hours Policy/Procedure: If you need to contact your therapist at any time, you may do so by leaving a message on the confidential voice mailbox at (727) 300-6688. If you are in an EMERGENCY situation, you will need to call 911 or the 24-hour Crisis Helpline at (800) 273-8255 (adults) & (800) 843-5200 (teens). You may also wish to go to a hospital emergency room for evaluation if you are concerned that you may be suicidal or homicidal. If you are in a crisis situation, I will schedule an appointment as soon as possible.

Death or Incapacity Plan: I acknowledge that, in the event the undersigned therapist becomes incapacitated or dies, a designated competent mental health professional will take possession of your file and make appropriate disposition.

Grievance/Complaint: Please discuss any concerns you may have with your therapist. You have the right to file a confidential grievance if you have any unresolved concern regarding the therapy/therapist. Any grievance should be addressed to the state board for Mental Health Therapists in your state which can be found online.

Consent to Treatment: I, voluntarily, agree to receive mental health assessment, care, and treatment/services from the undersigned therapist. I understand and agree that I will participate in the planning and treatment of my care and that I may stop such care at any time. By signing this consent, I, the undersigned client, acknowledge that I have both read and understood all of the terms and information contained herein. I acknowledge that I received a copy of this signed intake and consent form from my therapist on the date the document is signed as indicated below. Ample opportunity has been offered to me to ask questions and seek clarification of all the terms of this agreement. I have also received and read the Notice of Privacy Practices regarding my Protected Health Information and have had the opportunity to ask questions about and understand these policies.

_____

Client's Signature/ Date

_____

Additional Client's or Guardian's Signature/ Date

_____

As witnessed by

Please initial each page: _____